Booklet 3

Group Health Medical

Although these benefit descriptions include certain key features and brief summaries of King County regular employee and part-time Local 587 benefit plans, they are not detailed descriptions. If you have questions about specific plan details, contact the plan or Benefits and Retirement Operations. We've made every attempt to ensure the accuracy of this information. However, if there is any discrepancy between the benefit descriptions and the insurance contracts or other legal documents, the legal documents will always govern. King County intends to continue benefit plans indefinitely, but reserves the right to amend or terminate them at any time in whole or in part, for any reason, according to the amendment and termination procedures described in the legal documents. King County, as plan administrator, has the sole discretionary authority to determine eligibility for benefits and to construe the terms of the plans. This information does not create a contract of employment between King County and any employee.

Call 206-684-1556 for alternate formats.

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Overview

► Highlights of Coverage under Group Health

Here are a few highlights of your coverage under the Group Health plan:
- You do not pay an annual deductible under this plan
- You pay copays for office visits and prescription drugs
- You must select a Group Health primary care physician (PCP)
- Your PCP can provide and coordinate all services through the Group Health network unless you have an emergency or your PCP refers you outside the network
- You may self-refer to Group Health staff specialists directly, without going through your PCP
- Network benefits are generally paid at 100% after the copays.

► Important Facts

Many important topics – including laws, regulations and county provisions – affect more than just this plan and can change frequently. To be more efficient, and avoid repetition, the following related information appears only in the Important Facts booklet:
- Who's eligible for coverage
- How to enroll
- When coverage begins
- Changes you can make to your coverage
- When coverage ends and options for continuing it after you leave employment
- What happens to coverage in different situations
- Your rights and responsibilities under the plans.

Cost

When you receive medical care, you pay:
- Required copays at the time of the service
- Coinsurance amounts not covered by the plan
- Expenses for services or supplies not covered by the plan.

A billing fee may be charged by Group Health if copays or bills reflecting expenses not covered by the plan are not paid within 30 days of the billing date.

See "Plan Features" in this booklet for details on deductibles, copays and coinsurance amounts; also see the latest new hire guides and open enrollment materials for details about monthly premiums you must pay (if any) for coverage.

Preexisting Condition Limit

This plan does not have a preexisting condition limit. However, there is a waiting period for transplants and growth hormones (see "Transplants" and "Growth Hormones" in the "Covered Expenses under Group Health" section of this booklet).

If you end employment with King County, please refer to "Certificate of Coverage" in this booklet for information on how your participation in this plan can be credited against another plan with a preexisting condition limit.

How the Plan Works

► Plan Features

The following table identifies some plan features, including your out-of-pocket maximum and how benefits are determined for most covered expenses. The sections following the table contain additional details.

Plan Feature	Group Health
Provider choice	You choose a Group Health PCP who provides and coordinates most services through the Group Health network; you may also self-refer to Group Health staff specialists; no non-network coverage unless indicated
Annual deductible	None
Copays	See "Summary of Covered Expenses" for amounts
After the copays, the plan pays most covered services at this level ...	100% network
Until you reach your annual out-of-pocket maximum...	$1,000/person, $2,000/family for network care and limited emergency/out-of-area non-network care
Then, most benefits are paid for the rest of the calendar year at ...	100% network
Lifetime maximum	No limit

► Network Providers

Network providers may be either staff members of Group Health or contracted professionals. All providers who make up the network are carefully screened by Group Health. Doctors and other health care professionals must complete a detailed application to be considered for the network. The application covers education, status of board certification, malpractice and state sanction histories. For a list of network providers, contact Group Health (see the Resource Directory booklet).

► Out-of-Area Coverage

This plan does not provide out-of-area benefits except for emergency care. If you or a family member is away from home you may be able to access urgent or emergency care at network benefit levels in HMOs associated with Group Health. You or your family member can use the Kaiser Permanente network for urgent or emergency care while traveling. For out-of-area emergency care, contact 1-888-457-9516 or 1-888-901-4636.

► Selecting a Primary Care Physician

Your PCP is your personal doctor and can act as the coordinator of all your medical care. PCPs can be family or general practitioners, internists or pediatricians. If you need a specialist, your PCP can arrange it.

You are strongly encouraged to select a PCP from the Group Health network provider directory when you enroll. Each family member may have a different PCP. The provider directory is updated periodically; for current information about providers, contact Group Health (see Resource Directory booklet).

Continuity of your care is important, and easier to achieve if you establish a long-term relationship with your PCP. However, if you find it necessary to change your PCP, call Group Health.

► Specialists

Your PCP can provide or coordinate your medical care, including specialists. In most cases, your doctor will refer you to a network specialist. Or, if you wish, you may make appointments directly with any Group Health staff

specialist without a referral from your PCP. However, referrals are required to see contracted specialists. (You can tell the difference between a Group Health staff specialist and a contracted specialist because Group Health staff specialists practice in Group Health facilities.)

When you're referred to any network specialist (staff specialist or contracted specialist), be sure to get a copy of the referral form from your PCP and take it to the specialist. To allow your PCP to coordinate your care most effectively, check back with him or her after a specific time or number of specialist visits. If you have a complex or chronic medical condition, you may obtain a standing specialist referral.

If you see a non-network provider without a referral, benefits may not be payable.

► Annual Out-of-Pocket Maximum

The out-of-pocket maximum is generally the most you pay toward copays each plan year. This means once you reach your out-of-pocket maximum, the Group Health plan pays 100% of most covered expenses for the rest of the calendar year.

The following do not apply to the out-of-pocket maximum:
- Eyeglasses and contact lenses
- Health education
- Hearing aids
- Inpatient mental health
- Outpatient mental health
- Prescription drugs
- Residential day treatment
- Services and supplies not covered by the plan.

► Accessing Care

Generally, to receive benefits:
- You make an appointment with a network provider
- You pay a $20 office visit copay at the time you receive health care services
- After the copay, the plan pays 100% for most covered services and handles all forms and paperwork.

You may receive benefits when you see non-network providers in the following situations only:
- Emergency care
- If your network provider refers you to a non-network provider.

► Second Opinions

You may request a second opinion regarding a medical diagnosis or treatment plan from a network provider.

Covered Expenses under Group Health

► Summary of Covered Expenses

The table beginning on the following page summarizes covered services and supplies under this plan (only medically necessary services and supplies are covered) and identifies related coinsurance, copays, maximums and limits. Also see the sections after the table as well as "Expenses Not Covered."

Covered Expenses	Group Health
Alternative care	Self-referrals to a network provider are covered up to 5 visits/medical diagnosis/calendar year for acupuncture and up to 2 visits/medical diagnosis/calendar year for naturopathy; all other alternative care may require PCP referral All services are subject to the $20 copay/visit
Ambulance services	80%
Chemical dependency treatment	100% after $200 copay/admission for inpatient care 100% after $20 copay/visit for outpatient care $11,285 maximum/24 consecutive months (maximum subject to annual adjustment)
Chiropractic care and manipulative therapy (like all services, must be medically necessary)	100% after $20 copay/visit
Circumcision	100% after $20 copay/visit
Devices, equipment and supplies	80% if authorized in advance by a network provider as medically necessary
Diabetes care training	100% after $20 copay/visit
Diabetes supplies (insulin, needles, syringes, lancets, etc.)	Covered under prescription drugs
Emergency room care	100% after $75 copay/visit to network facility ($75 copay is waived but $200 copay/admission for hospital care applies if admitted) 100% after $125 copay/visit to non-network facility ($125 copay applies in addition to $200 copay/admission for hospital care if admitted) Non-emergency care not covered
Family planning	100% after $20 copay/visit (infertility treatment not covered)
Growth hormones	Covered under prescription drugs if medical coverage has been continuous for more than 12 months under this plan
Hearing aids	100% up to $300/ear in 36 months
Home health care	100%
Hospice care	100% when preauthorized
Hospital care	100% after $200 copay/admission
Infertility treatment	Not covered
Inpatient care alternatives	100%
Lab, x-ray and other diagnostic testing	100%
Massage therapy (like all services, must be medically necessary)	100% after $20 copay/visit with PCP referral
Maternity care	100% for delivery and related hospital care after $200 copay/admission 100% after $20 copay/visit for prenatal and postpartum care
Mental health care	80% up to 12 days/year for inpatient 100% after $20 copay/individual, family or couple visit or $10 copay/group session for outpatient Up to 20 outpatient visits/year

Covered Expenses	Group Health
Neurodevelopmental therapy for covered family members age 6 and under	100% for inpatient services after $200 copay/admission up to 60 days/condition/year 100% after $20 copay/visit for outpatient up to 60 visits/year for each condition
Out-of-area coverage for your children away at school	Reciprocal benefits available through Kaiser Permanente and affiliated HMOs; only emergency services covered in all other areas
Physician and other medical/surgical services	100% after $20 copay/visit
Phenylketonuria (PKU) formula	100%
Prescription drugs – up to 30-day supply through network pharmacies	100% after $10 copay for generic 100% after $20 copay for preferred brand 100% after $30 copay for non-preferred brand No reimbursement for prescriptions filled at non-network pharmacies
Prescription drugs – up to 90-day supply through mail order	100% after $20 copay for generic 100% after $40 copay for preferred brand 100% after $60 copay for non-preferred brand
Preventive care (check-ups, immunizations, routine health and hearing exams, etc.)	100% (according to well-child/adult preventive care schedule) Immunizations for travel not covered
Radiation therapy, chemotherapy and respiratory therapy	100% after $20 copay/visit
Reconstructive services (includes benefits for mastectomy-related services – reconstruction and surgery to achieve symmetry between the breasts, prostheses and complications resulting from mastectomy, including lymphedema; call plan for more information)	100% depending on services provided; copays may apply (including $200 copay/admission if hospital care required)
Rehabilitative services	100% for inpatient services after $200 copay/admission up to 60 days/condition/calendar year 100% after $20 copay/visit for outpatient services Up to 60 visits/year/condition
Skilled nursing facility	100% up to 60 days/calendar year at a Group Health-approved nursing facility
Smoking cessation	100% for 1 Group Health network provider program/year 100% or the amount of a prescription drug copay (whichever is less) for nicotine replacement therapy up to 30-day supply
Temporomandibular joint (TMJ) disorders	100% for inpatient care after $200 copay/admission 100% after $20 copay/visit for outpatient care Up to $1,000/year and a $5,000 lifetime maximum
Transplants	100% after applicable copays Medical coverage must have been continuous for more than 12 months under this plan – whether preexisting or an emergency
Urgent care (ear infections, high fevers, minor burns, etc.)	100% after $20 copay/visit
Vision exams	100% after $20 copay/visit up to 1 exam/person in 12 consecutive months (Group Health provides exams only; your separate Vision Service Plan provides eye exams, prescription lenses and frames)

► Alternative Care

Covered services include:
- Acupuncture; covered up to five visits per medical diagnosis in a calendar year
- Chiropractic; must be medically necessary; covered up to 10 visits per year
- Home births; you may see any Group Health network midwife for covered prenatal and home birth services
- Massage therapy; must be medically necessary and part of a formal rehabilitation program
- Naturopathy; covered up to two visits per medical diagnosis in a calendar year.

You can self-refer for acupuncture, chiropractic and naturopathy care but network provider referral is required for home births and massage therapy.

► Ambulance Services

Services of an ambulance company are covered if:
- Ordered or approved by your PCP
- Other transportation would endanger your health, and
- The transportation is not for personal or convenience reasons.

► Chemical Dependency Treatment

Your PCP can arrange chemical dependency services, or for outpatient care, you may call Group Health Behavioral Health at 1-888-287-2680.

Treatment may include the following inpatient or outpatient services:
- Covered prescription drugs and medicines
- Diagnostic evaluation and education
- Organized individual and group counseling.

Detoxification services are covered as any other medical condition and are not subject to the chemical dependency limit. Chemical dependency means a physiological and/or psychological dependency on a controlled substance and/or alcohol, where your health is substantially impaired or endangered, or your ability to function socially or to work is substantially disrupted.

► Chiropractic Care and Manipulative Therapy

Medically necessary manipulative therapy of the spine and extremities is covered. You do not need a referral from your PCP before you see a network chiropractor or osteopath. Associated x-rays are covered when provided at a Group Health radiology facility.

► Devices, Equipment and Supplies

Covered equipment and appliances include:
- Nasal CPAP devices
- Orthopedic appliances
- Post-mastectomy bras
- Prosthetic devices.

Durable medical equipment is covered if:
- Designed for prolonged use
- It has a specific therapeutic purpose in treating your illness or injury
- Prescribed by your PCP and part of the Group Health formulary, and
- Primarily and customarily used only for medical purposes.

Covered items include:
- Artificial limbs or eyes (including implant lenses prescribed by a network provider and required as a result of cataract surgery or to replace a missing portion of the eye)
- Casts, splints, crutches, trusses or braces
- Diabetic equipment for home testing and insulin administration not covered under the prescription benefit (excluding batteries)
- External breast prosthesis (covered at 100%) and bra following mastectomy (covered at 50%); one external breast prosthesis is available every two years (per diseased breast), and two post-mastectomy bras are available every six months (up to four in any consecutive 12 months)
- Non-prosthetic orthopedic appliances attached to an impaired body segment; these appliances must protect the body segment or aid in restoring or improving its function
- Ostomy supplies
- Oxygen and equipment for its administration
- Purchase of nasal CPAP devices and initial purchase of associated supplies (you must rent the device for one month before purchase to establish compliance)
- Rental or purchase (decided by the plan) of durable medical equipment such as wheelchairs, hospital beds and respiratory equipment (combined rental fees may not exceed full purchase price).

► Diabetes Care Training and Supplies

Diabetes care training includes diet counseling, enrollment in diabetes registry and a wide variety of education materials; these are covered under the prescription drug benefit.

Covered supplies include:
- Blood glucose monitoring reagents
- Diabetic monitoring equipment
- External insulin pumps
- Insulin syringes
- Lancets
- Urine testing reagents.

► Emergency Care

Emergency care treats medical conditions that threaten loss of life or limb, or may cause serious harm to the patient's health if not treated immediately. You do not need a referral from your PCP before you receive emergency room care.

Examples of conditions that might require emergency care include:
- An apparent heart attack (chest pain, sweating, nausea)
- Bleeding that will not stop
- Convulsions
- Major burns
- Severe breathing problems
- Unconsciousness or confusion, especially after a head injury.

If you need emergency care, follow these steps:
- Dial 911 or go to the nearest hospital emergency room immediately. In cases when you can choose an emergency location, go to the Eastside Hospital in Redmond; this will allow us to coordinate your care efficiently and perhaps reduce your expenses.
- When you arrive, show your Group Health ID card.
- If you're admitted to a non-network facility, you must call 1-888-457-9516 within 24 hours; otherwise you may be responsible for all costs incurred before you call. If you are unable to call, have a friend, relative or hospital staff person call for you. The plan's phone number also is printed on the back of your ID card.

- If you are admitted to a health care facility, you must notify Group Health within 24 hours. You may be required to transfer your care to a network provider and/or Group Health facility. If you refuse to transfer to a Group Health facility, all further costs incurred during the hospitalization are your responsibility.

In general, follow-up care that is a direct result of the emergency must be received through Group Health. Non-emergency use of an emergency facility is not covered.

► Family Planning

Covered family planning expenses include:
- Family planning counseling
- Services to insert intrauterine birth control devices (IUDs)
- Sterilization procedures
- Voluntary termination of pregnancy.

The plan does not cover:
- Infertility treatment, sterility or sexual dysfunction treatment or diagnostic testing
- Procedures to reverse voluntary sterilization.

Birth control drugs are covered under the prescription drug benefit.

► Growth Hormones

Growth hormones are covered, subject to the prescription drug copay. You or your family member will not be eligible for any growth hormone benefits until the first day of the 13th month of continuous coverage under this plan (unless continually covered under this plan from birth).

► Hearing Aids

Hearing aids (including fitting, rental and repair) are covered at the level shown in the "Summary of Covered Expenses" in this booklet.

► Home Health Care

Home health care is covered if the patient is unable to leave home due to health problems or illness and the care is necessary because of a medically predictable, recurring need. Unwillingness to travel and/or arrange for transportation does not constitute an inability to leave home. If you have an approved plan of treatment and referral from a network provider, covered expenses include:
- Medical social worker and limited home health aide services
- Nursing care
- Occupational therapy
- Physical therapy
- Respiratory therapy
- Restorative speech therapy.

The following services are not covered:
- Any care provided by a member of the patient's family
- Any other services rendered in the home that are not specifically listed as covered
- Custodial care or maintenance care
- Housekeeping or meal services
- Private duty or continuous care in the patient's home.

► Hospice Care

Hospice care is a coordinated program of supportive care for a dying person by a team of professionals and volunteers. The team may include a physician, nurse, medical social worker, physical, speech, occupational or respiratory therapist or home health aide under the supervision of a registered nurse.

Hospice services are covered if:
- A network provider determines the patient's illness is terminal, with life expectancy of six months or less, and can be appropriately managed in the home or hospice facility
- The patient has chosen comforting and supportive services rather than treatment aimed at curing their terminal illness
- The patient has elected in writing to receive hospice care through the Group Health-approved hospice program, and
- The patient has a primary care person who will be responsible for the patient's home care.

One period of continuous home care hospice service is covered. A continuous home care period is skilled nursing care provided in the home 24 hours a day during a period of crisis to maintain a terminally ill patient at home. A network provider must determine the patient would otherwise require hospitalization.

Continuous respite care may be covered for up to five days per occurrence of hospice care. Respite care must be given in the most appropriate setting as determined by your network provider.

The following services are not covered:
- Any services provided by members of the patient's family
- Custodial care or maintenance care
- Financial or legal counseling (examples are estate planning or the drafting of a will)
- Funeral arrangements
- Homemaker, caretaker or other services not solely related to the patient, such as:
- House cleaning or upkeep
- Meal services
- Sitter or companion services for either the plan participant who is ill or for other family members
- Transportation.

► Hospital Care

The following hospital care expenses are covered under this plan:
- Drugs listed in the plan formulary
- Hospital services
- Room and board
- Special duty nursing.

► Infertility

Infertility treatment is not covered under this plan.

► Injury to Teeth

Injuries to teeth are not covered under this plan.

► Inpatient Care Alternatives

See "Skilled Nursing Facility" and "Home Health Care" sections.

► Lab, X-ray and Other Diagnostic Testing

This plan covers diagnostic x-ray, nuclear medicine, ultrasound and laboratory services. See "Preventive Care" in this booklet for more information on routine diagnostic testing (for example, mammograms).

► Maternity Care

Maternity care is covered if provided by a:
- Physician
- Provider licensed as a midwife by Washington State.

Covered maternity care includes:
- Complications of pregnancy or delivery
- Hospitalization and delivery, including home births and certain birthing centers for low-risk pregnancies
- Postpartum care
- Pregnancy care
- Related genetic counseling when medically necessary for prenatal diagnosis of an unborn child's congenital disorders
- Screening and diagnostic procedures during pregnancy.

The plan does not cover home pregnancy tests.

Group health plans and health insurance issuers offering group coverage generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn to less than 48 hours following a vaginal delivery or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother and/or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

► Mental Health Care

Inpatient and outpatient mental health services are covered. These services place priority on restoring social and occupational functioning; they include:
- Consultations
- Crisis intervention
- Evaluation
- Intermittent care
- Managed psychotherapy
- Psychological testing.

Your PCP can arrange for mental health services or you can contact Group Health Behavioral Health directly by calling 1-888-287-2680. (Counseling and referral services are also available through King County's Making Life Easier Program by calling 1-888-874-7290.)

The following mental health services are not covered:
- Custodial care
- Day treatment
- Specialty programs for mental health therapy not provided by Group Health
- Treatment of sexual disorders.

► Neurodevelopmental Therapy

The plan covers neurodevelopmental therapy for covered family members age six and younger, including:
- Hospital care

- Maintenance of the patient when his or her condition would significantly worsen without such services
- Occupational, speech and physical therapy (if ordered and periodically reviewed by a physician)
- Physicians' services
- Services to restore and improve function.

The plan does not cover:
- Implementation of home maintenance programs
- Physical, occupational or speech therapy services when available through government programs
- Programs for the treatment of learning problems
- Therapy for degenerative or static conditions when the expected outcome is primarily to maintain the patient's level of functioning.

► Newborn Care

The plan covers newborns under the mother's coverage for the first three weeks, as required by Washington State law. To continue the newborn's coverage after three weeks, the newborn must be eligible and enrolled by the deadline as described in the Important Facts booklet.

► Physician and Other Medical/Surgical Services

Several other medical and surgical services are covered by this plan, including:
- Blood and blood derivatives and their administration
- Diabetic supplies (insulin syringes, lancets, urine-testing reagents and blood-glucose monitoring reagents)
- Nonexperimental implants limited to cardiac devices, artificial joints and intraocular lenses
- Outpatient diagnostic radiology and lab services
- Outpatient radiation therapy and chemotherapy
- Outpatient surgical services
- Outpatient total parenteral nutrition therapy
- Services of a podiatrist (routine foot care not covered)
- Services performed by a network provider or oral surgeon (reduction of a fracture or dislocation of the jaw or facial bones, excision of tumors or cysts of the jaw, cheeks, lips, tongue, gums, roof or floor of the mouth, incision of salivary glands and ducts; accidental injury to teeth not covered)
- Treatment of growth disorders by growth hormones.

► PKU Formula

The plan covers the medical dietary formula that treats phenylketonuria (PKU).

► Prescription Drugs

Benefits are provided for legend drugs (prescription drugs with an 11-digit code assigned by the labeler or distributor under FSA regulations) and other covered items (including insulin, injectables and contraceptive drugs and devices) when you use a network pharmacy or mail order, including off-label use of FDA-approved drugs. To be covered, prescriptions must be:
- Filled through a network pharmacy or mail order
- Prescribed by a network provider for covered conditions.

The plan does not cover:
- Dental prescriptions
- Drugs for cosmetic uses
- Drugs for treatment of sexual dysfunction
- Drugs not approved by the FDA and in general use as of March 1 of the previous year
- Over-the-counter drugs.

To fill your prescription through a network pharmacy, show the pharmacist your Group Health card. For mail order prescriptions, your provider first prescribes a 30-day "trial" supply and you fill it through a network pharmacy. If the trial supply is effective, you order a 90-day supply by contacting the mail order service through the Group Health website (see Resource Directory booklet) or calling 1-800-245-7979. The service mails your prescription to your home.

If you need a refill, check the label on the prescription container; some may be refilled without consulting your provider. The number of refills is indicated on the label. If you need your provider's approval to refill your medication, call your pharmacy or the mail order service at least two weeks before you run out of medication. The pharmacy/mail order service will need time to order your medicine and contact your provider for approval.

You may receive up to a 30-day supply per copay from a network pharmacy and up to a 90-day supply per copay from the network mail order service (see "Summary of Covered Expenses" for copay amounts). Generic drugs are used whenever available. Brand-name drugs are used if there is no generic equivalent. If available at the network pharmacy, you may buy specific brand-name drugs by paying the higher copay.

► Preventive Care

The plan covers the following preventive care:
- Most immunizations and vaccinations for adults and children (except immunizations for travel)
- Routine hearing exams (once in 12 consecutive months)
- Routine mammograms (age and risk factor determine frequency)
- Routine physicals for adults and children (age and risk factor determine frequency)
- Routine vision exams (once in 12 consecutive months).

► Radiation Therapy, Chemotherapy and Respiratory Therapy

Covered expenses include radiation therapy, high-dose chemotherapy and stem cell support, and respiratory therapy services.

► Reconstructive Services

Reconstructive services are covered to correct a congenital disease/anomaly or a medical condition (following an injury or incidental to surgery) that had a major effect on the patient's appearance (the reconstructive services must, in the opinion of a network provider, be reasonably expected to correct the condition).

Covered individuals receiving benefits for a mastectomy who elect breast reconstruction in connection with the mastectomy, as determined in consultation with the patient and attending physician, have these benefits:
- Prosthesis and treatment of physical complications of all stages of mastectomy, including lymphedemas
- Reconstruction of the breast on which the mastectomy has been performed
- Surgery and reconstruction of the healthy breast to produce a symmetrical appearance.

These reconstructive benefits are subject to the same copays and coinsurance provisions as other medical and surgical benefits.

► Rehabilitative Services

Covered inpatient and outpatient rehabilitative services are limited to physical, occupational and speech therapy to restore function after illness, injury or surgery.

The plan does not cover:
- Implementation of home maintenance programs
- Physical, occupational or speech therapy services when available through government programs
- Programs for the treatment of learning problems

- Therapy for degenerative or static conditions when the expected outcome is primarily to maintain the patient's level of functioning.

Rehabilitative services are covered only when the plan determines they are expected to result in significant, measurable improvement within 60 days. Rehabilitative services for chronic conditions are not covered.

► Skilled Nursing Facility

Skilled nursing facility services are covered, when referred by a network provider, to a maximum of 60 days each calendar year.

► Smoking Cessation

You do not need a PCP referral before you see a network provider for these services.

Services related to tobacco cessation are covered, limited to:
- One course of nicotine replacement therapy a year if you're actively participating in the Group Health Free and Clear Program
- Educational materials
- Participation in one program a year from a network provider.

► TMJ Disorders

Medical and surgical services and related hospitalizations to treat temporomandibular joint (TMJ) disorders are covered when medically necessary, subject to the limits in the "Summary of Covered Expenses." Orthognathic (jaw) surgery, radiology services and TMJ specialist services, including the fitting and adjustment of splints, also are covered. TMJ appliances are covered under the orthopedic appliances benefit (see "Devices, Equipment and Supplies").

The following services, including related hospitalizations, are not covered by the plan regardless of origin or cause:
- All dental services (except as noted above), including orthodontic therapy
- Orthognathic (jaw) surgery in the absence of a TMJ diagnosis
- Treatment for cosmetic purposes.

Additional benefits are available through the dental plan (see Washington Dental Service booklet).

► Transplants

You or your family member will not be eligible for any organ transplant benefits until the first day of the 13th month of continuous coverage under this Group Health plan (unless continuously covered under this plan since birth).

The following transplants are covered:
- Bone marrow
- Cornea
- Heart
- Heart-lung
- Kidney
- Liver
- Lung (single or double)
- Pancreas/kidney (simultaneous).

Transplant services must be received at a facility designated by Group Health and are limited to:
- Evaluation testing to determine recipient candidacy

- Follow-up services for specialty visits, rehospitalization and maintenance medications
- Transplantation (limited to costs for surgery and hospitalization related to the transplant, as well as medications).

The plan covers the following donor expenses for a covered organ recipient:
- Excision fees
- Matching tests
- Procurement center fees
- Travel costs for a surgical team.

The plan does not cover:
- Donor costs reimbursable by the organ donor's insurance plan
- Living expenses
- Transportation expenses (except as listed above).

► Urgent Care

Sometimes you may need to see a physician for conditions that are not life threatening but need immediate medical attention. For example:
- Ear infections
- High fevers
- Minor burns.

For urgent care during office hours, call your PCP's office for assistance.

After office hours, call Group Health's Consulting Nurse Service at 1-800-297-6877. Depending on your situation, the consulting nurse may provide instructions over the phone for self-care, instruct you to make an appointment with your PCP for the next day or advise you to go to the nearest urgent care or emergency room.

Urgent care is covered the same as other care. Generally, urgent care involves an office visit and is paid at the level shown in the "Summary of Covered Expenses" in this booklet.

► Vision Exams

This plan covers routine vision exams only. Your separate Vision Service Plan provides eye exams, prescription lenses and frames (see Vision Service Plan booklet).

Expenses Not Covered

In addition to the exclusions or limits described in other sections of this booklet, the Group Health plan does not cover:
- Artificial or mechanical hearts
- Benefits covered by other insurance
- Cardiac or pulmonary rehabilitation
- Complications of non-covered surgical services
- Conditions resulting from service in the armed forces, declared or undeclared war or voluntary participation in a riot, insurrection or act of terrorism
- Convalescent or custodial care
- Corrective appliances or artificial aids including eyeglasses, contact lenses or services related to their fitting
- Cosmetic services, including treatment for complications of cosmetic surgery that is elective or not covered
- Court-ordered services or programs not judged medically necessary by the network provider
- Dental care, surgery, services and appliances, except as described in "Physician and Other Medical/Surgical Services" in this booklet
- Diabetic meals and some diabetes education materials

- Evaluations and surgical procedures to correct refractions not related to eye pathology
- Exams, tests or shots required for work, insurance, marriage, adoption, immigration, camp, volunteering, travel, license, certification, registration, sports, recreational or school activities
- Experimental or investigational treatment
- Gambling or other specialty treatment programs
- Hypnotherapy or any related services
- Medicine or injections for anticipated illness while traveling
- Methadone maintenance programs
- Obesity treatment, services or items, except for nutritional counseling by network staff
- Orthopedic shoes not attached to an orthopedic appliance or arch supports (including custom shoe inserts or their fitting except for therapeutic shoes and shoe inserts for severe diabetic foot disease)
- Orthoptic (eye training) therapy
- Over-the-counter drugs (medicines and devices not requiring a prescription)
- Personal comfort items, such as phones or television
- Physical exams, immunizations or evaluations primarily for the protection and convenience of third parties, including obtaining or continuing employment or insurance or government licensure
- Routine foot care
- Services or supplies resulting from the loss or willful damage to covered appliances, devices, supplies or materials provided by Group Health
- Services provided by government agencies, except as required by federal or state law
- Sterility, infertility or sexual dysfunction testing or treatment including Viagra, penile implants, vascular or artificial reconstruction, sterilization reversal or sex transformations
- Weight reduction programs
- Work-incurred injury, illness or condition treatment.

Coordination of Benefits

► Coordination of Benefits between Plans

If you and a family member both have your own Group Health coverage, your copays (and those of children you both cover) are waived. Otherwise, if you and a family member have coverage through different plans, the King County Group Health plan coordinates benefits under its standard coordination of benefits (COB) policy between primary and secondary plans. If Group Health is primary, it pays first; if it is secondary it pays up to an amount equal to the difference between the total charge and what the primary plan paid (the exact amount depends on a calculation of COB savings to Group Health).

While the plan covering an individual as an employee is primary and pays first, the following guidelines determine what plan is primary for dependent children covered under two parents with different medical plans ("parents" in this case may not be blood related, but providing coverage through a marriage or domestic partnership):

- The plan of the parent whose birthday is first in the calendar year pays for covered children first unless the parents are divorced or legally separated. (If the other plan does not have this rule, its provisions apply.)
- If the parents are divorced or legally separated, these rules apply:
  - If a court decree establishes financial responsibility for the child's health care, the plan of the parent with that responsibility pays first.
  - If there is no court decree, the plan of the parent with custody (or primary residential placement) pays before the plan of the parent without custody.
  - If the parent with custody has remarried, the plan that covers the child is determined in this order: plan of the parent with custody, plan of the spouse of the parent with custody, plan of the parent without custody, plan of the spouse of the parent without custody.

If these provisions don't apply, the plan that has covered the employee longer pays first. Nevertheless, if either parent is retired, laid off or a family member of a retired or laid-off person, the plan of the person actively employed pays first (unless the other plan doesn't have a provision regarding retired or laid-off employees).

The plans have the right to obtain and release data as needed to administer these coordination of benefit procedures.

► Coordination of Benefits with Medicare

If you keep working for the county after age 65 you may:
- Continue your medical coverage under a county plan and integrate the county plan with Medicare (the county plan would be primary).
- Discontinue your county medical coverage and enroll in Medicare. If you choose this option, your covered family members are eligible for continuation of coverage under COBRA for up to 36 months (see "COBRA" in the Important Facts booklet).

Federal rules govern coordination of benefits with Medicare. In most cases, Medicare is secondary to a plan covering a person as an active employee or family member of an active employee. Medicare is primary in most other circumstances.

If you have any questions about how your coverage coordinates with Medicare, contact your medical plan (see the Resource Directory booklet).

Filing a Claim

► What to Do

If you receive care from a network provider, the provider submits claims for you. If you receive emergency services from a non-network provider, you pay the provider in full, and it's your responsibility to submit a claim form to Group Health or have the provider submit one for you. Claim forms are available from Group Health (see the Resource Directory booklet).

When submitting any claim, you need to include your itemized bill. It should show:
- Patient's name
- Provider's tax ID number
- Diagnosis or ICD-9 code
- Date of service/supply
- Itemized charges from the provider for the services/supplies received.

You also need to provide:
- Your name (if you were not the patient)
- Your Social Security number (or unique identifier number if assigned one by your plan)
- Group number (shown on your Group Health ID card and available from Benefits and Retirement Operations).

For prompt payment, submit all claims as soon as possible. The plan will not pay a claim submitted more than 12 months after the date of service/supply. If you can't meet the 12-month deadline because of circumstances beyond your control, the claim will be considered for payment when accompanied by a written explanation of the circumstances.

► How the Claim is Reviewed

Group Health will review your claim and notify you or your provider in writing within the following timeframes:
- Within 72 hours for urgent claims. Urgent claims are claims for services where your provider believes a delay in treatment could seriously jeopardize your life, health or ability to regain maximum function, or cause

severe pain that can't be controlled adequately without the care being considered. Urgent claims can be submitted by phone or fax (see the Resource Directory booklet). You will be notified of the claim review decision by phone with a written notice to follow.

- Within 15 days for pre-service claims (within 30 days if an extension is filed). Pre-service claims are those where the plan requires you to obtain approval of the benefit before receiving the care. The plan may ask for a one-time extension of 15 days to request additional information. Once notified of the extension, you have 45 days to provide any missing information.
- Within 24 hours for concurrent claims. Concurrent claims are those for continuation of services previously approved by the claim administrator as an ongoing course of treatment or to be provided over a certain period.
- Within 30 days for post-service claims (within 60 days if an extension is filed). Post-service claims are claims that aren't urgent, pre-service or concurrent. The plan may ask for a one-time extension of 30 days to request additional information. Once notified of the extension, you have 45 days to provide any missing information.

The claim administrator reviews your claim, applying plan provisions and their discretion in interpreting plan provisions, and then notifies you of the decision within the timeframes listed above.

► If the Claim is Approved

If the claim is approved and there is no indication the bill has been fully paid, payment for covered services is made to the provider. If the bill indicates full payment has been made to the provider, payment for covered services is made directly to you.

► If the Claim is Denied

If the claim is denied, you are notified in writing of the reasons for the denial, the right to appeal and the right to obtain copies of all documents related to the claim that Group Health reviewed in making the determination.

Appealing Denied Claims

► Claims Denied for Reasons Other Than Eligibility

If a properly filed claim is denied in whole or in part, Group Health notifies you and your provider with an explanation in writing. When a claim is denied for any reason other than eligibility, follow the steps described in this section. However, when a claim is denied for eligibility reasons, follow the steps described in the next section, "Claims Denied Due to Eligibility."

If you or your representative disagrees with the claim denial, you may try to resolve any misunderstanding by calling Group Health and providing more information. If you'd rather communicate in writing or the issue isn't resolved with a call, you may file a written appeal (see the Resource Directory booklet for contact information.)

You have 180 days after receiving a claim denial notice to file a written appeal. Be sure to include the reasons for the appeal and any information or documentation helpful to reviewing the claim.

Group Health will review the written appeal and notify you or your representative of their decision within these timeframes:

- Within 72 hours for urgent appeals
- Within 14 days for pre-service appeals
- Within 30 days for post-service appeals
- Within the timeframes for urgent, pre-service or post-service appeals for concurrent appeals, depending on the nature of the claim.

Your appeal is reviewed by someone different from the original decision makers and without deference to the initial decision. The appeal reviewer applies plan provisions and their discretion in interpreting plan provisions,

and then notifies you of the decision within the timeframes listed above. If the claim appeal is denied, you are notified in writing of reasons for the denial.

Group Health has sole discretionary authority to determine benefit payment under the plans; their decisions are final and binding.

If the appeal is denied, legal remedies may be pursued, but you or your representative must exhaust this claim appeal process first. If legal action is taken, the suit must be filed within two years after the event the claim is based on or you forfeit your right to legal action.

► Claims Denied Due to Eligibility

If you have eligibility questions or believe you've had a claim denied because the plan indicates you or a family member is not covered, call Benefits and Retirement Operations at 206-684-1556. A staff member may be able to resolve the eligibility issue, eliminating the need to file a formal appeal.

If you'd rather communicate in writing or your eligibility issue can't be resolved with a phone call, you or your representative (referred to as "you" in the rest of the section) may file a written appeal. You have 180 days after receiving an eligibility determination notice (from the county or the plan) to submit a written appeal. It must include:

- Your name and address as well as each covered family member's name and address (if applicable)
- Hire letter or job announcement, or retirement determination of eligibility
- Your employee ID (as it appears on your pay stub) or Social Security number (even if the appeal is for a family member)
- Reason for the appeal.

Send eligibility appeals to:

King County Benefits and Retirement Operations
Exchange Building EXC-ES-0300
821 Second Avenue
Seattle WA 98104-1598

A Benefits and Retirement Operations staff member will review your appeal and notify you of the eligibility determination within these timeframes:

- Within 72 hours for urgent appeals (call 206-684-1556 to file an urgent appeal)
- Within 14 days for pre-service appeals (within 30 days if an extension is filed)
- Within 20 days for post-service appeals (within 40 days if an extension is filed)
- Within the timeframes for urgent, pre-service or post-service appeals for concurrent appeals, depending on the nature of the claim.

If your eligibility appeal is denied, the notice will include the plan provision behind the decision and advise you of your right to obtain free copies of relevant documentation.

Benefits and Retirement Operations has sole discretionary authority to determine benefit eligibility under this plan; its decision is final and binding. In reviewing your claim, Benefits and Retirement Operations applies the plan terms and uses its discretion in interpreting plan terms. Benefits are paid only if you meet the eligibility and participation requirements and Benefits and Retirement Operations determines you're entitled to the benefits.

If you believe your eligibility appeal was denied because relevant information or documents were not considered, Benefits and Retirement Operations offers the option of filing an eligibility appeal addendum within 60 days after receiving the eligibility appeal denial notice. The addendum must include the relevant information or documents. Send eligibility appeal addendums to the same address for eligibility appeals, but to the attention of the Benefits and Retirement Operations Manager.

The manager will review the additional information you provide, consult with appropriate county personnel and notify you in writing of the eligibility determination. The notice will indicate the specific plan provision behind the decision and advise you of your right to obtain free copies of related documentation.

It is the manager's exclusive right to interpret and apply the eligibility terms and exercise discretion to resolve all eligibility questions for county employees. Decisions of the manager are final and binding.

If you disagree with your eligibility appeal determination, you may file a grievance with your union or initiate legal action. Any legal action must be within two years of the date you or your family member is denied plan participation, or you forfeit your right to legal action.

Release of Medical Information

As a condition of receiving benefits under this plan, you and your family members authorize:

- Any provider to disclose to the plan any requested medical information
- The plan to examine your medical records at the offices of any provider
- The plan to release to or obtain from any person or organization any information necessary to administer your benefits
- The plan to examine records that would verify eligibility.

The plan will keep this information confidential whenever possible, but under certain necessary circumstances, it may be disclosed without specific authorization.

Certificate of Coverage

When your coverage under this plan ends, you automatically receive a certificate of health plan coverage. This is an important document and should be kept in a safe place. You may take this certificate to another health plan to receive credit against a preexisting condition limit for the time you were covered under this plan.

Converting Your Coverage

If you're no longer eligible for the medical coverage described in this booklet, you may transfer your coverage to an insured conversion plan. The plan you convert to will differ from the benefits described in this booklet. You must pay premiums, which may be higher than amounts you currently pay (if any) for these benefits.

You will not be able to convert to the individual policy if you are eligible for any other medical coverage under any other group plan (including Medicare).

To apply for a conversion plan, you must complete and return an application form to Group Health within 31 days after this medical coverage terminates. Evidence of insurability will not be required. You will not receive this application or information about conversion plan coverage unless you request it from Group Health.

Extension of Coverage

If this plan is canceled, Group Health will continue to cover any participants who are hospital inpatients on the cancellation date. Coverage ends on the date of discharge or when the participant reaches the plan maximums, whichever comes first.

Payment of Medical Benefits

The medical benefits offered by this plan are insured by Group Health, meaning this is not a self-funded plan. Group Health is financially responsible for claim payments and other costs.